Sandwell
Metropolitan Borough Council

VISION 2030 SANDWELL

Complex Risk Assessment Screening Tools (C.R.A.S.T.)

screening tools

Each part of the CRAST is in itself a brief intervention, you are not completing this tool because it is a requirement, the tool is to be used when something has given you cause for concern in one of the areas (Alcohol, Nutrition, Cognition, Drugs, Gambling, Depression or anxiety). The tool is provided to enable you to structure a discussion around a difficult subject, find out more, and provide appropriate levels of reinforcement, advice or support, including brief interventions or referral to medical providers or specialist services. You will need the person's consent for each individual set of questions, you will also need consent to share the results as part of any referrals that follow. A set of Brief Intervention Tools is also available to support practitioners to act according to the scores in the CRAST. For more tools visit SMART!

Contents

Printing Guide

The most eco-friendly way to use this tool is on a touch screen device with a stylus pen, however the most user-friendly way will be with a pen on paper; so when printing paper versions to use, please consider what you are concerned about and **only print pages that you may use**.

In each section of this tool, only one page needs to be printed, the other page is for instruction only. Therefore, **p1** - CRAST, **p3** - AUDIT, **p6** - MST, **p7** - 6-CIT, **p9** - DAST, **p11 & 12** - PGSI, **p13** - PHQ-9 & GAD-7, and **p17** - WWD Checklist, are the only pages you may need to print in the tool, they do not need to be printed in colour, **please print in B&W and only print what you need**.

The referral forms for the Cranstoun Substance Misuse Service and the Cranstoun Blue Light Team are included as **appendices 1 and 2,** only print if needed.

Complex Risk Assessment Screening Tool (CRAST)

Sandwell in the West Midlands

Name: ……..…. …… **Worker:** …… …… **Date:** _ _/ _ _/ _ _

Ask the screening questions only if you have concerns in that area, then refer to page 2.

AUDIT: Alcohol Use in the past 6 months

1. How often do you have a drink containing alcohol?

Never	Monthly or less	Weekly	2-3 times a week	Daily
☐0	☐1	☐2	☐3	☐4

2. How many units of alcohol do you drink typically when you are drinking?

1-2	3-4	5-6	7-9	10+
☐0	☐1	☐2	☐3	☐4

3. Have you had 6 or more units (F), or 8 or more (M), on a single occasion?

Never	Occasionally	Monthly	Weekly	Daily
☐0	☐1	☐2	☐3	☐4

AUDIT Score:

MST: Diet and Nutrition in the last 6 months

1. Have you lost weight without trying recently?
   a. No ☐0
   b. Unsure ☐2
   c. Yes, how much?
      - 1-5 kg (2-13 lbs) ☐1
      - 6-10 kg (14-23 lbs) ☐2
      - 11-15 kg (24-33 lbs) ☐3
      - 16+ kg (34+ lbs) ☐4
      - Unsure ☐2
2. Have you been eating poorly because of decreased appetite?
   a. No ☐0
   b. Yes ☐1

MST Score:

DUDIT: Problem drug use in the past 6 months

1. How often are you heavily under the influence of drugs?
   Never ☐0 Occasionally ☐1 Monthly ☐2 Weekly ☐3 Daily ☐4
2. How often have you felt that you needed drugs to feel well or better?
   Never ☐0 Occasionally ☐1 Monthly ☐2 Weekly ☐3 Daily ☐4
3. Have you not done something you should have done because of using drugs?
   Never ☐0 Occasionally ☐1 Monthly ☐2 Weekly ☐3 Daily ☐4

DUDIT Score:

Complex Risk Assessment Screening Tool (CRAST)

The CRAST is a screening tool for alcohol use, malnutrition, and problem drug use in the past six months.

AUDIT: Alcohol Use in the past 6 months

The Alcohol Use Disorders Identification Tool (AUDIT) was developed by the World Health Organisation (WHO) and has been used in a variety of health and social care settings.

A score of **less than 5** indicates lower risk drinking, an opportunity to raise awareness and give positive reinforcement. **Scores of 5+** require further assessment with full AUDIT for Alcohol (p3). This is also available as an online test WHO/Europe | Alcohol use - Take the AUDIT test now

MST: Diet and Nutrition in the last 6 months

The Malnutrition Screening Tool (MST) is used worldwide, it is adapted from Ferguson M, et al. 1999.

STEP 1: Screen with the MST, add weight loss and appetite scores
STEP 2: Score to determine risk
STEP 3: Intervene according to scoring. Use the 'Nutrition Risk Identification Questions' (p6) to identify any issues that might be contributing.

Scoring

- A **score of 0-1** means the person is at low risk of malnutrition, review every 3 to 6 months.
- A **score of 2** means the person may be at risk of malnutrition. Use appropriate brief interventions to support people to deal with any issues that you identify. Review in two to three months.
- A **score of 3-5** means the person is at high risk of malnutrition.
- Refer to persons G.P. or a Practising Dietitian promptly if weight and/or food intake does not improve quickly following efforts to address identified issues.

DUDIT: Problem drug use in the past 6 months

The 3 screening questions are adapted from The Drug Use Disorders Identification Test (DUDIT) manual. Bergman, A.H., et al. 2003.

A score of **less than 5** indicates lower risk drug use, an opportunity to give brief harm reduction advice and positive reinforcement. **Scores of 5+** require further assessment with the full DAST for substance use (p9).

Alcohol Use Disorders Screening Tool (AUDIT)

Sandwell in the West Midlands

Name: .... **Worker:** .... **Date:** _ _/ _ _/ _ _

The Alcohol Use Disorders Identification Tool (AUDIT) was developed by the World Health Organisation (WHO) and modified for use in the UK and has been used in a variety of health and social care settings. [*Alcohol use screening tests - GOV.UK*]

AUDIT-C Questions	Scoring					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total score:	

A score of **less than 5** indicates lower risk drinking (see overleaf).
Scores of 5+ require the following 7 questions to be completed:

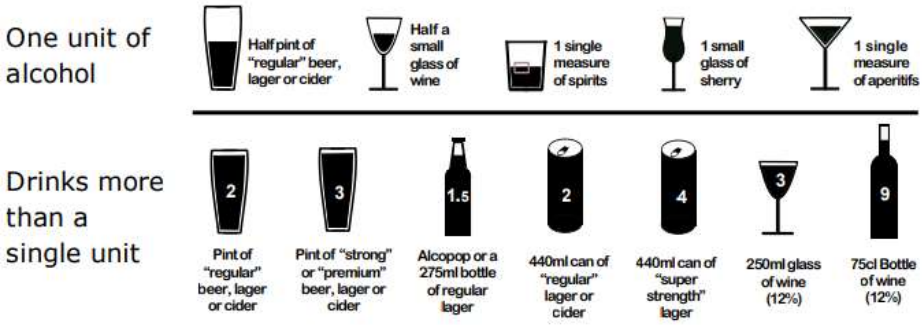
For AUDIT translations in 40 languages:
AUDIT translations (auditscreen.org)

AUDIT Questions	Scoring					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, in the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, in the last year	
					Total score:	

SCORING: ADD the 2 scores together to identify necessary action

AUDIT C _____ + AUDIT _____ = _____

Alcohol unit reference



https://alcoholchange.org.uk/alcohol-facts/interactive-tools/check-your-drinking/alcohol-units

AUDIT score intervention guide

AUDIT Score	Risk Category	Desired Action
0-7	Lower Risk	Positive reinforcement of low risk drinking guidelines
8-15	Increasing Risk	Brief intervention, reinforce low risk guidelines and explore strategies for cutting down
16-19	Higher Risk	Extended Brief Intervention and / or referring to local services for Brief Treatment.
20+	High Risk and Possible Dependence	Refer to specialist treatment services, if refused give safer drinking tips & use brief motivational interventions to promote treatment.

0-7 Simple Brief Advice: An opportunity to educate people about low risk drinking levels and the risks of excessive alcohol use. **NB: It is never safe to drink alcohol at all during pregnancy.**

8-15 Brief Intervention to Reduce Use: Person-centered discussion that uses motivational enhancement concepts to raise an individual's awareness of their substance use and enhance their motivation to change behaviour. Brief interventions are typically 5-15 minutes and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behaviour change is to cut back to low risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication, etc.).

16-19 Brief Intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up: People with numerous or serious negative consequences from their alcohol use, or people who likely have an alcohol use disorder who cannot or are not interested in obtaining specialised treatment, should receive more numerous and intensive Brief Interventions with follow up. The recommended behaviour change is to cut back to low risk drinking levels or abstain from use. Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available (see below), if brief treatment is not available, secure follow-up in 2-4 weeks.

20+ Brief Intervention to Accept Referral: The focus of the brief intervention is to enhance motivation for the person to accept a referral into treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for assessment and, if warranted, treatment. The aim is for the person to reduce use and accept the referral.

Refer to Cranstoun Sandwell (appendix 1) who offer brief treatment groupwork and one-to-one support to reduce drinking, as well as interventions to manage health problems caused by drinking. **For severe and chaotic drinkers or substance users who may be placing a high demand on blue light or other services, contact the Blue Light Project at Cranstoun (0121-553-1333) to discuss assertive outreach support.**

The Malnutrition Screening Tool (MST) is an easy to use, two-question screening tool. It gives a score out of five to show the level of malnutrition risk. It can be used to decide how to help and what follow-up is needed. Use this BMI chart to open a discussion about healthy weight and regular eating.

Weight

Height

	lbs	90	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290
	kgs	41	45	50	54	59	64	68	72	77	82	86	91	95	100	104	109	113	118	122	127	132
ft/in	cm																					
4 ft 8 in	142.2	20	22	25	27	29	31	34	36	38	40	43	45	47	49	52	54	56	58	61	63	65
4 ft 9 in	144.7	19	22	24	26	28	30	32	35	37	39	41	43	45	48	50	52	54	56	58	61	63
4 ft 10 in	147.3	19	21	23	25	27	29	31	33	36	38	40	42	44	46	48	50	52	54	56	59	61
4 ft 11 in	149.8	18	20	22	24	26	28	30	32	34	36	38	40	42	44	46	48	51	53	55	57	59
5 ft 0 in	152.4	18	20	21	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57
5 ft 1 in	154.9	17	19	21	23	25	26	28	30	32	34	36	38	40	42	43	45	47	49	51	53	55
5 ft 2 in	157.4	16	18	20	22	24	26	27	29	31	33	35	37	38	40	42	44	46	48	49	51	53
5 ft 3 in	160.0	16	18	19	21	23	25	27	28	30	32	34	35	37	39	41	43	44	46	48	50	51
5 ft 4 in	162.5	15	17	19	21	22	24	26	27	29	31	33	34	36	38	39	41	43	45	46	48	50
5 ft 5 in	165.1	15	17	18	20	22	23	25	27	28	30	32	33	35	37	38	40	42	43	45	47	48
5 ft 6 in	167.6	15	16	18	19	21	23	24	26	27	29	31	32	34	36	37	39	40	42	44	45	47
5 ft 7 in	170.1	14	16	17	19	20	22	24	25	27	28	30	31	33	34	36	38	39	41	42	44	45
5 ft 8 in	172.7	14	15	17	18	20	21	23	24	26	27	29	30	32	33	35	37	38	40	41	43	44
5 ft 9 in	175.2	13	15	16	18	19	21	22	24	25	27	28	30	31	33	34	35	37	38	40	41	43
5 ft 10 in	177.8	13	14	16	17	19	20	22	23	24	26	27	29	30	32	33	34	36	37	39	40	42
5 ft 11 in	180.3	13	14	15	17	18	20	21	22	24	25	27	28	29	31	32	33	35	36	38	39	40
6 ft 0 in	182.8	12	14	15	16	18	19	20	22	23	24	26	27	28	30	31	33	34	35	37	38	39
6 ft 1 in	185.4	12	13	15	16	17	18	20	21	22	24	25	26	28	29	30	32	33	34	36	37	38
6 ft 2 in	187.9	12	13	14	16	17	18	19	21	22	23	24	26	27	28	30	31	32	33	35	36	37
6 ft 3 in	190.5	11	13	14	15	16	18	19	20	21	23	24	25	26	28	29	30	31	33	34	35	36
6 ft 4 in	193.0	11	12	13	15	16	17	18	19	21	22	23	24	26	27	28	29	30	32	33	34	35
6 ft 5 in	195.5	11	12	13	14	15	17	18	19	20	21	23	24	25	26	27	28	30	31	32	33	34
6 ft 6 in	198.1	10	12	13	14	15	16	17	18	20	21	22	23	24	25	27	28	29	30	31	32	34
6 ft 7 in	200.6	10	11	12	14	15	16	17	18	19	20	21	23	24	25	26	27	28	29	30	32	33
6 ft 8 in	203.2	10	11	12	13	14	15	16	18	19	20	21	22	23	24	25	26	27	29	30	31	32
6 ft 9 in	205.7	10	11	12	13	14	15	16	17	18	19	20	21	24	24	25	26	27	28	29	30	31
6 ft 10 in	208.2	9	10	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
6 ft 11 in	210.8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	25	26	27	28	29	30

Underweight Healthy Overweight Obese Extremely Obese

Key points to remember

- Malnutrition is preventable and reversible.
- Consistent gradual weight loss can add up to significant weight loss and malnutrition over time.
- Overweight/ obese clients who have unexplained weight loss or decreased appetite can be at risk of malnutrition too.
- After you assess that a client is at risk, it is important to identify what may be contributing to this risk, and to act quickly.
- This screening tool identifies those at risk of malnutrition but is not intended to be used to diagnose malnutrition. This can be done by a G.P.

Nutrition Risk Identification Questions

If a person has been identified as 'at risk' of malnutrition (by having a score between 2 – 5) on the MST, work through the following questions to help understand why they might be at risk, there may be more than one contributing issue. Help them to manage these issues, to reduce the impact of malnutrition risk. Document all concerns, and the strategies undertaken to address them.

Use motivational techniques to encourage the person to see their G.P. who will undertake appropriate tests, provide supplements, and refer to specialist health services if necessary.

Adapted from; Identifying and Planning Assistance for Home-based Adults who are Nutritionally at risk: A Resource Manual. Dietitians Assoc of Australia; 2000 and the Australian Nutrition Screening Initiative (ANSI).

Name: .... **Worker**: .... **Date**: _ _/ _ _/ _ _

Nutrition Risk Identification Questions

1. Do you have any teeth, mouth or swallowing problems that make it hard for you to eat?

Yes☐ No☐ Comments:

2. Do you have any difficulties shopping, cooking or feeding yourself?

Yes☐ No☐ Comments:

3. Do you have any difficulty with storing your food or keeping your kitchen clean?

Yes☐ No☐ Comments:

4. Do you have an illness or condition that makes you change the kind or amount of food you eat?

Yes☐ No☐ Comments:

5. Do you take three or more different medications each day?

Yes☐ No☐ Comments:

6.Do you eat alone most of the time?

Yes☐ No☐ Comments:

7. Are there times when you find it hard to afford groceries?

Yes☐ No☐ Comments:

8. Do you eat at least three meals each day?

Yes☐ No☐ Comments:

9. Do you eat meat, chicken, eggs or fish each day?

Yes☐ No☐ Comments:

10. Do you consume milk, cream, yoghurt, cheese or custard each day?

Yes☐ No☐ Comments:

11. Do you eat fruit or vegetables most days?

Yes☐ No☐ Comments:

12. Do you have three or more drinks of beer, wine or spirits most days?

Yes☐ No☐ Comments:

13. Do you have at least eight cups of fluids each day?

Yes☐ No☐ Comments:

Review/ reassessment date: _ _ / _ _ / _ _ _ _

The Drug Abuse Screening Tool (DAST)

Sandwell in the West Midlands

Name: .... **Worker**: .... **Date**: _ _/ _ _/ _ _

Using drugs can affect your health and some medications you may take. Please help us provide you with the best care by answering the questions below.

Which substances have you used in the past year? (Check all that apply)

- ☐ heroin, methadone
- ☐ fentanyl, oxycontin
- ☐ cocaine
- ☐ crack
- ☐ tranquilisers (valium, zopiclone, nitrazepam, benzodiazepines)
- ☐ psychedelics (mushrooms, lsd, DMT)
- ☐ cannabis, skunk, resin, oil
- ☐ inhalants (gas, glue, paint thinners)
- ☐ khat
- ☐ speed, amphetamines, base
- ☐ methamphetamines, crystal meth
- ☐ ecstasy, mdma, 2cb
- ☐ ketamine, ghb
- ☐ novel psychoactive substances (spice, m-cat, mamba, etc)
- ☐ steroids, weight-loss pills
- ☐ other (please list): .....

How often have you used these drugs?

☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

DAST Questions	No (0)	Yes (1)
1. Have you used drugs other than those required for medical reasons?	☐	☐
2. Do you use more than one drug at a time?	☐	☐
3. Are you unable to stop using drugs when you want to?	☐	☐
4. Have you ever had blackouts or flashbacks as a result of drug use?	☐	☐
5. Do you ever feel bad or guilty about your drug use?	☐	☐
6. Does your spouse (or parents) ever complain about your use of drugs?	☐	☐
7. Have you neglected your family because of your use of drugs?	☐	☐
8. Have you engaged in illegal activities in order to obtain drugs?	☐	☐
9. Have you ever experienced withdrawal symptoms when you stopped taking drugs?	☐	☐
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	☐	☐
11. Do you inject your drugs?	☐	☐
12. Have you ever been in treatment for substance use?	☐	☐
Total:	0	

Circle score:	I	II	III	IV
	0	1-2	3-5	6+

Scoring and interpreting the DAST:

1. "Yes" responses are one point, "No" responses are zero points. All response scores are added for a total score.

2. The total score correlates with a zone of use, which can be circled on the bottom right corner.

Score*	Zone	Explanation	Action
0	I – Low Risk	Someone at this level is not currently using drugs and is at low risk for health or social complications.	Reinforce positive choices and educate about risks of drug use.
1 - 2	II – Risky	Someone using drugs at this level may develop health problems or existing problems may worsen.	Brief Intervention to reduce or abstain from use and raise awareness of potential risks and harms.
3 - 5	III – Harmful	Someone using drugs at this level has experienced negative effects from drug use.	Brief Intervention to reduce use, raise awareness of potential risks/ harms, and specific follow-up interventions. Referral to Cranstoun for Brief Treatment.
6-12	IV – Severe	Someone using drugs at this level could benefit from more assessment and assistance.	Brief Intervention to accept referral to specialty treatment for a full assessment.

0 = Simple Brief Advice: Reinforce positive choices and educate about risks of drugs used.

1-2 = Brief Intervention to Reduce Use or Abstain from Using: Person-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of their drug use and enhance their motivation towards behavioural change. Brief interventions are 5-15 minutes and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behaviour change is to decrease or abstain from use.

3-5 = Brief intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up: People with numerous or serious negative consequences from their drug use, or people who likely have a substance use disorder who cannot or are not willing to obtain specialised treatment, should receive more numerous and intensive interventions with follow up. The recommended behaviour change is to abstain from use. Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available (see below). If brief treatment is not available, secure follow-up in 2-4 weeks.

6-12 = Brief Intervention to Accept Referral: The focus of the brief intervention is to enhance motivation for the patient to accept a referral into treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for diagnostic assessment and, if warranted, treatment. The recommended behaviour change is to accept the referral and consider reducing or stopping the drug use.

Refer to Cranstoun-Sandwell (appendix 1) who offer groupwork and one-to-one support to reduce drug using behaviour, alternate prescribing options, as well as interventions to manage health problems caused by drug use. **For severe and chaotic drinkers or substance users who may be placing a high demand on blue light services contact the Blue Light Project at Cranstoun (0121-553-1333) to discuss assertive outreach support.**

**Gavin, D. R., Ross, H. E., and Skinner, H. A. Diagnostic validity of the DAST in the assessment of DSM-III drug disorders. British Journal of Addiction, 84, 301-307. 1989. More resources: www.sbirtoregon.org*

PGSI mini screen

Name: .... **Worker**: .... **Date**: _ _/ _ _/ _ _

This instrument is formed of three questions from the PGSI, which are scored on a 4-point scale from never to almost always. It is asked to all participants of a survey who have gambled at least once in the last 12 months.

PGSI: In the last 12 months…

never = zero; **sometimes** = one; **most of the time** = two; **almost always** = three

1. Have you bet more than you could really afford to lose?
2. Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
3. Have you felt guilty about the way you gamble or what happens when you gamble?

PGSI Score:

Scoring instructions

0	Non-problem gambler - Gamblers who gamble with no negative consequences
1	Low-risk gambler - Gamblers who experience a low level of problems with few or no identified negative consequences
2-3	Moderate-risk - Gamblers who experience a moderate level of problems leading to some negative consequences
4+	Problem gambler - Gambling with negative consequences and a possible loss of control

The short-form Problem Gambling Severity Index (PGSI mini-screen) was developed for the Commission from the full 9-item PGSI by Dr. Rachel Volberg, 2012.

https://www.gamblingcommission.gov.uk/statistics-and-research/publication/problem-gambling-screens

Online Self-assessment tool

If you are not sure how much gambling has become a problem for you, you can take an online assessment Self-assessment tool - GamCare to find out how much of an impact gambling is having in your life.

The assessment will give you a series of statements and ask you to select how much the statement applies to your gambling behaviour on a scale of 1 – 10.

At the end of the test you will be presented with a breakdown of how gambling is affecting your life and will give you personalised recommendations for your next steps.

https://www.gamcare.org.uk/understanding-gambling-problems/self-assessment-tool/

Problem Gambling Severity Index (PGSI)

Name: .... **Worker**: .... **Date**: _ _/ _ _/ _ _

Used in the Health Survey for England, Scottish Health Survey, and the Welsh Problem gambling Survey. The PGSI consists of nine items and each item is assessed on a four-point scale: never, sometimes, most of the time, almost always. Responses to each item are given the following scores:

Thinking about the last twelve months… **never = 0; sometimes = 1; most of the time = 2; almost always = 3**	Score
Have you bet more than you could really afford to lose?	
Have you needed to gamble with larger amounts of money to get the same feeling of excitement?	
When you gambled, did you go back another day to try to win back the money you lost?	
Have you borrowed money or sold anything to get money to gamble?	
Have you felt that you might have a problem with gambling?	
Has gambling caused you any health problems, including stress or anxiety?	
Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?	
Has your gambling caused any financial problems for you or your household?	
Have you felt guilty about the way you gamble or what happens when you gamble?	
Total:	

Scoring instructions

0	Non-problem gambler - Gamblers who gamble with no negative consequences.
1-2	Low-risk gambler - Gamblers who experience a low level of problems with few or no identified negative consequences.
3-7	Moderate-risk - Gamblers who experience a moderate level of problems leading to some negative consequences. Give encouragement to explore online resources and a brief intervention to reduce or abstain from gambling.
8+	Problem gambler - Gambling with negative consequences and a possible loss of control. Brief intervention to reduce and accept referral to a specialist service.

When scores to each item are summed, a total score ranging from 0 to 27 is possible. A PGSI score of eight or more represents a problem gambler. This is the threshold determined by the developers of the PGSI .

https://www.gamblingcommission.gov.uk/statistics-and-research/publication/problem-gambling-screens

Help with gambling problems

In the West Midlands the organisation commissioned by GamCare is **Aquarius** who provide support for people 16 years and over affected by gambling, either their own or that of a family member or friend, through 1-2-1 or group support sessions.

People can self-refer to this service or be referred by a professional. To find out more or refer call: **0300 456 4293** or email: gambling@aquarius.org.uk

6-CIT Memory Impairment Test

Name: .... **Worker**: .... **Date**: _ _/ _ _/ _ _

Try to perform this test in a quiet place with **no obvious clock or calendar visible** to the person.

Question	Score Range	Score
1. **What year is it?**	**0 – 4** Correct - 0 points Incorrect - 4 points	
2. **What month is it?**	**0 – 3** Correct - 0 points Incorrect - 3 points	
3. **Tell the person that you are going to tell them a fictional address that you would like them to try and memorise and then repeat back to you afterwards. Say:** **John, Smith, 42, High Street, Bedford** Make sure that the person is able to repeat the address correctly before moving on and warn them to try and memorise it as you are going to ask them to repeat it again in a few minutes. No score is made at this stage.		
4. **About what time is it?** (they only need to get within 60 minutes of the time to score correctly)	**0 – 3** Correct - 0 points Incorrect - 3 points	
5. **Are you able to count backwards from 20 – 1?**	0 – 4 Correct - 0 points 1 error - 2 points More than 1 error - 4 points	
6. **Can you say the months of the year in reverse?** (give them plenty of time for this and it doesn't matter if they have to keep saying the months of the year forwards in order to get the answer. Inevitably they sometimes forget where they were, you can prompt them or offer encouragement that they're doing well).	**0 – 4** Correct - 0 points 1 error - 2 points More than 1 error - 4 points	
7. **Finally, can you repeat the address back to me?** John, Smith, 42, High Street, Bedford The address is broken into 5 segments and is scored for each error they make.	**0 – 10** Correct - 0 points 1 error - 2 points 2 errors - 4 points 3 errors - 6 points 4 errors - 8 points All wrong - 10 points	
TOTAL SCORE	0 – 28	/ 28

Outcome from Score

0 – 7	Probably no cognitive impairment
8 – 9	Some cognitive impairment
10 – 28	Significant cognitive impairment

The 6-CIT is validated in the UK (6-CIT- Kingshill Version 2000). *The Kingshill Research Centre, Swindon, UK owns the copyright to The Kingshill Version 2000 of the 6-CIT but allows free usage to healthcare professionals.*

The Six Item Cognitive Impairment Test (6-CIT) was developed in 1983 by Katzman et al in the USA. It consists of six questions that are simple, non-cultural, and don't require any complex interpretation.

The 6-CIT test is not a mental capacity assessment in respect of specific decision making, a capacity test would need to be done separately if needed. A person may have cognitive impairment and still be able to make some decisions.

You should have a score of between 0 & 28, which should be interpreted as follows:

- 0-7 Probably not cognitively impaired
- 8-9 Some cognitive impairment
- 10-28 Significant cognitive impairment requiring more detailed assessment or referral

Users should be aware that a small subgroup of people with dementia, (especially those with Fronto-Temporal disease) will perform normally on most short cognitive screening tests, therefore, if the tester believes there to be a significant clinical history of cognitive impairment the person should be referred even with a score in the normal range.

- **Number of questions**: 6.
- **Time taken to perform**: 3-4 minutes.
- **Score**: the 6CIT uses an inverse score and questions are weighted to produce a total out of 28. Scores of 0-7 are considered normal and 8 or more significant.
- **Advantages**: the test has high sensitivity without compromising specificity, even in mild dementia. It is easy to translate linguistically and culturally.
- **Disadvantages**: the main disadvantage is in the scoring and weighting of the test, which may be initially confusing; however, computer models have simplified this greatly.
- **Probability statistics**: at the 7/8 cut-off: Overall figures - sensitivity = 90%, specificity = 100%; in mild dementia, sensitivity = 78%, specificity = 100%.

The 6-CIT is available as a free download application for Apple or Android phones and you can email yourself the results with a timestamp. The App will add up the score for you and interpret the result and guide you as to what to do next i.e. refer to the person's G.P. for referral to a specialist brain injury clinic.

Actions

0-7 scored: Reassure the person that things seem well. If they are worried, encourage them do something to maintain cognitive functioning such as daily crosswords or sudoku puzzles, or simply reading.

8-9 scored: If you still have concerns support them to seek further testing from their G.P. and referral to a memory clinic or neurology. You could assist the person with advice and guidance on keeping the mind active and maintaining memory functionality, such as memory exercises, crosswords, sudoku, simply reading or talking to others. Keeping people connected to others for company and conversation is one of the five ways to wellbeing (Five-Ways-to-Wellbeing.pdf).

10-28 scored: Encourage and support them to seek further testing from their G.P. for referral to a memory clinic or neurology. Consideration will need to be given to undertaking an MCA assessment if there are specific decisions to be made, e.g. in relation to consent for information sharing or further assessments. If alcohol use has possibly caused the impairment and they are still drinking, use the AUDIT tool, discuss the risks of continued drinking and work towards a referral to Cranstoun.

Sandwell in the West Midlands

PHQ-2 & PHQ-9

Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	Over half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep/ sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Add the score for each column:	0 +	+	+	=
			Total:	

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all difficult	Somewhat difficult	Extremely difficult	Very difficult

Name: .... **Worker:** .... **Date:** _ _/ _ _/ _ _

Generalised Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column:	0 +	+	+	=
			Total:	

8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all difficult	Somewhat difficult	Extremely difficult	Very difficult

Name: .... **Worker:** .... **Date:** _ _/ _ _/ _ _

Interpreting your PHQ-9 depression screening results

The PHQ-9 is a clinically validated screening tool that is used to screen for depression, and to diagnose and monitor the severity of the condition. Anyone can take the PHQ-9 and receive actionable results; the first two questions of the PHQ-9 make up the PHQ-2. The questions address sleep, energy, appetite, and other possible symptoms of depression. Scores are calculated based on how frequently a person experiences these feelings.

Score	Depression Severity	Recommended Actions
0 - 4	Minimal	This is considered *minimal depression*, which suggests that the respondent may not need depression treatment.
5 - 9	Mild	This is considered *mild depression,* which might warrant closer observation and re-evaluation after a certain period of time.
10 - 14	Moderate	This is considered *moderate depression,* generally leading to recommendations for therapeutic interventions or medication.
15 - 19	Serious	This is considered *moderately severe depression,* and either antidepressants or counselling would likely be appropriate.
20 - 27	Severe	This is considered *severe major depression*, the best treatment approach may be a combination of antidepressant medication and psychotherapy (therapeutic counselling).

What comes next?

Although a PHQ-9 score can tip you off to the presence of depression, a keyworker can only help you with mental health issues if you speak up, you can access self-help resources, be referred for therapeutic support or medical treatment if appropriate.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

The PHQ-9 and the GAD-7 and translations are downloadable from **https://www.phqscreeners.com/select-screener** and **no permission** is required to reproduce, translate, display or distribute them.
See also https://www.anxietyuk.org.uk/gad7-phq9/ and PDFfiller - PHQ-9 & GAD-7.pdf

Interpreting your GAD-7 generalised anxiety screening results

The Generalised Anxiety Disorder Assessment (GAD-7)is a self-administered patient questionnaire and it takes about 1-2 minutes to complete. The GAD-7 has been validated for primary care patients, general population, and adolescents. GAD-7 is used to measure or assess the severity of generalised anxiety disorder (GAD), it is also good for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder.

Score	Depression Severity	Recommended Actions
0 - 4	Minimal	Give feedback and reassurance to build skills to manage anxiety.
5 - 9	Mild	Recommend they discuss with G.P. Signpost to online resources and/ or provide self-help worksheets.
10 - 14	Moderate	Likely diagnosis of GAD; G.P. to confirm by further evaluation and refer to therapeutic services.
15 - 21	Severe	Probable diagnosis of GAD; G.P. to confirm by further evaluation, to refer to psychiatric services for the best treatment approach may be a combination of medication and therapeutic counselling.

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006;166:1092-1097. The GAD-7 is free to use.

Name: …… …… **Worker**: …… …… **Date**: _ _/ _ _/ _ _

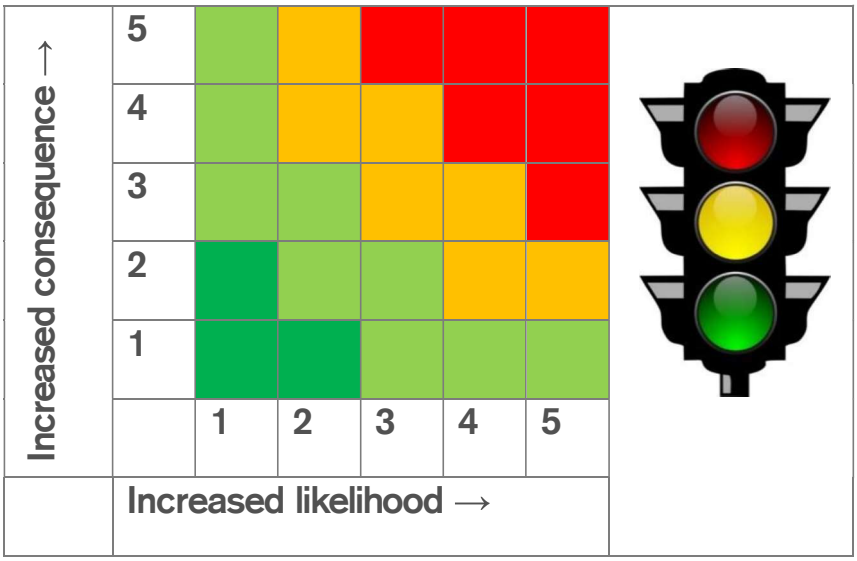
This checklist aims to help professionals to develop the best relationship with and intervention for the person you are supporting *(Alcohol Change UK, 2021).*

Have I taken the time needed to assess the person I'm supporting, usually across multiple meetings, at least once in their home?	
Have I expressed 'concerned curiosity', characterised by gentle persistence, skilled questioning, conveyed empathy and genuine relationship-building?	
Have I undertaken a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes?	
Have I undertaken a thorough mental capacity assessment, which includes understanding and consideration of executive capacity, recognising that being articulate and scoring well in cognition tests can mask difficulties?	
Have I undertaken a thorough mental health assessment, with particular attention at points of transition, for example hospital discharge or placement in supported accommodation?	
Have I undertaken a comprehensive risk assessment, especially in situations of service refusal?	
Have I avoided assuming that negative behaviours are 'a lifestyle choice' and developed a deeper understanding of what might lie behind their refusal to engage for example loss, trauma, shame and fear?	
Have I taken time to consider the impact of adverse experiences, including issues of loss and trauma, and explored any repetitive patterns?	
Have I understood how the person's faith, age, gender, sexuality and ethnicity may be impacting on the nature and presentation of their needs?	
Have I built up a picture of the person's history to help to uncover what is driving and maintaining self-neglect in the form of alcohol abuse?	
Have I recognised the person's assets as well as their needs and risks?	
Have I used a person-centred approach that demonstrates proactive rather than reactive engagement?	
Have I considered whether and how family involvement may be of benefit, to both the drinker and to them?	
Have I considered how to ensure our response is creative, for example making use of peer support, text messaging, online technology, playfulness, etc?	
Have I maintained contact and been reliable, even when the person appears not to be engaging?	

Where risks are reasonably foreseeable an assessment should be made of the likelihood of an undesirable outcome against the consequences of it occurring. This matrix is to be used to screen the significance of the risk(s).

Overall Risk Scale

Low	Moderate	High	Critical



Likelihood

Scale	Factor	Indicators
5	Extremely likely	Frequent/ Regular risk has been identified that could have life threatening and severe consequences
4	Very likely	Risk very likely to impact on individual wellbeing without immediate intervention person is at risk of harm and neglect
3	Likely	Likely to impact on wellbeing without intervention
2	Unlikely	Unlikely to happen if support is in place
1	Remote	Considered risk and no probability of risk.

Consequence

Scale	Factor	Personal Safety
5	Critical	Life Threatening
4	High	Severe consequence of harm and neglect without intervention
3	Moderate	The risk will have a considerable impact to wellbeing
2	Low	Risk of harm, discomfort or distress that can be monitored and reviewed as part of assessment and support planning
1	Minimal	Minor concern that has no immediate threat of harm or neglect.

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Empowering People, Empowering Change

PLEASE SEND TO
e: sandwellreferrals@cranstoun.org.uk
tel: 0121 553 1333 fax: 0121 358 9630

REFERRAL & INITIAL CONTACT FORM

Date:		Form Completed by:	
Client name:		Referring Agency:	
D.O.B.:		Referrer Contact details:	
Address:	If NFA use ZZ99 3VZ	GP details:	
Contact Number:		Gender:	
Ethnicity:		Birth Country? Interpreter required? language?	
Are you able to access video conferencing apps/sites (Zoom, Skype etc)		Preferred appt time:	AM/PM

In line with the GDPR 2018 please tick the box to confirm that you have discussed the referral with your client and they have agreed to it being made: (This must be ticked)	

Substance (most problematic first):	Frequency (e.g. daily, 2-3 times daily etc):	Amount (£/units/qty):	Days per week:	Route:	Harm Min Advice (*Internal use only*: Ensure inputted on CarePath)
1.					
2.					
3.					
4.					

Any identified risks: please tick and add details to all that apply.					
Substance Related			Safeguarding Children: *Children present? Risk of CSE? Social Services Involved?*		
Mental Health: *Neglect? Any Prescribed medication?*			Physical health: *Pregnant? Any prescribed medication?*		
Domestic Abuse/ Risk from others: *FGM, MDS*			Housing/ Financial/ Social:		Housing need/ NFA/ no housing problem
Criminal Justice Involved / Risk to others:			Barriers to engagement: *Communication difficulties?*		

Additional Information: *Please detail any other concerns or risks relating to this referral, include any other agency involvement, consent and contact details or anything else relevant to this referral. Include details of services engaged at present with contact information.* Preferred means of contact (circle all that apply)- Telephone Letters Text Email

This page for internal use only

In compliance with the Cranstoun confidentiality policy, please tick box to confirm the confidentiality agreement and circumstances under which confidentiality would be breached have been discussed and agreed with the client (See below)	

Confidentiality (to be discussed with client at referral stage):

We run a confidential service. However, information about you and / or your treatment may need to be discussed with various health and social care partners to ensure you are provided with the best care possible. This will be discussed further at assessment.

There are a few exceptional circumstances where we could disclose information without consent:

- *If it is believed that the welfare and safety of children and young people under 18 are being put at risk.*
- *If you express an intent to harm yourself or we have any concerns about your immediate welfare.*
- *If you express an intent to harm or cause injury to a third party.*
- *If Cranstoun Sandwell is instructed by a court of law to reveal information about you.*
- *If you provide specific details about a serious crime which has been committed or is to be committed (for example: murder, rape, serious offence against another person).*

Any decision to breach confidentiality is treated very seriously and if we are able, we will notify you of this and our reasons for doing so.

Please ensure referral details are added as a care path case note under a referral intervention. Include a summary of client circumstances and appropriate harm minimisation and advice given (when appropriate).

Risk assessment needs to be completed on carepath and appropriate steps identified for self-referrals.

All areas listed on the opposite side need to be completed and recorded on carepath.

Ensure consents are updated on carepath as much as possible at this stage.

If client already exists on carepath add a new treatment episode rather than creating a new client. Open client at Tiers 1-2.

appendix 2: BLUE LIGHT REFERRAL FORM

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PLEASE SEND TO

email: bluelightsandwell@cranstoun.org.uk

Date		**Referrer Name**	
Client name		**Referring Agency**	
D.O.B.		**Referrer Contact details**	
Address		**GP details**	
Contact Number		**Gender**	
Ethnicity		**Interpreter required? Y/N Which language?**	
Any other communication difficulties			
In line with the GDPR 2018 please tick the box to confirm that you have discussed the referral with your client and they have agreed to it being made.			

Substances (frequency/amount/days/route) including prescribed medication

Any identified risks: please tick and add details to all that apply					
Violence			**Mental or Physical Health**		
Safeguarding Children/Adults			**Pregnant**		
Offending			**Domestic Abuse**		
Neglect			**Housing**		
Risk to/from others			**Other**		

appendix 2: BLUE LIGHT REFERRAL FORM

A definition of the Blue Light client group (must meet each of these three criteria):

i	**A substance misuse problem**
	• Have an enduring pattern of problem drinking or class A drug use, dating back a number of years (at least 10 years drinking and 2-3 years of class A drug use) • Those with an alcohol problem are likely to: score 20+ on AUDIT **OR** • Be classified as dependent on SADQ (16-30 = moderate dependence/30 is severe dependence range is 0-60) **OR** • Have other markers of dependence on alcohol (Ethanol levels or biomarkers such as LFT scores may also be used)
ii	**A pattern of not engaging with or benefiting from substance misuse treatment**
	• Have been referred to specialist substance misuse services, usually on more than two occasions, and have not attended, attended and then disengaged or remained engaged but not changed.
iii	**Place an exceptional demand on public services**
	Clients will either directly, or via their effect on others e.g. their family, be placing a high demand on at least one of the following services: • Health (primary care, secondary care or the ambulance trust) • Social care including adults involved with children's services • Criminal Justice / ASB / Domestic violence Services • Emergency services (999) • Housing and homelessness agencies The demand will be mainly due to: • Multiple use of multiple services • Multiple use of individual services • Placing an exceptional demand on services because of a single risk (e.g. a high risk sex offender released from prison with a pattern of problematic drinking).

Outcome measurement will be based on information on the impact on public services

What period does this data cover (e.g. last 12 months)?	
In 12 months prior to acceptance by Assertive Outreach	
Number of police call outs to this person	
Number of arrests	
Number of court appearances	
Number of prisons stays and length	
Number of ASB incidents (including begging & street drinking)	
Number of ambulance callouts to this person	
Number of A&E attendances	
Number of hospital admissions	
Number of safeguarding referrals	
Number of mental health appointments	
Number of substance misuse service appointments	
Number of other health appointments (e.g. GP, consultant, outpatient clinic)	
Number of fire service call out due to this person	
Other (please explain)	

Produced by Sandwell Adult's Social Care. Please send any corrections, amendments or suggestions to: nick1_shough@sandwell.gov.uk

The BADST-2 and the CRAST with the accompanying Short Brief Intervention Tools (SBIT's) for Alcohol, Drugs, and Wellbeing can be downloaded in pdf format at www.ourguideto.co.uk where you will also find the DECCA Awareness Club and further resources.

Further training in drugs awareness and substance misuse is provided by Cranstoun in Sandwell. To find dates and book places go to:

https://www.eventbrite.com/e/supporting-people-who-use-alcohol-or-other-drugs-in-sandwell-tickets-288542677917

For alcohol and drugs information, news, and further resources go to: https://cranstoun.org/help-and-advice/alcohol-other-drugs/sandwell/

If you live in Sandwell and are thinking about reducing the amount you are drinking, you can also access an app which can identify how much you are drinking and offers advice on how you can cut down.

The Lower My Drinking app can be downloaded through Google Play or iTunes, it is available in English and Polish.

As GamCare partner in the Midlands, Aquarius provide support, information and advice to anyone suffering with a gambling problem, as well as to family members and friends affected by someone else's gambling.

Further training in the use of these tools and the Short Brief Intervention Tools is available to book on the website of the Sandwell Safeguarding Action Board (SSAB) https://training.sandwelllscb.org.uk/

CRAST Feedback Form

If you have used any part of the CRAST in your practice, we would appreciate your feedback to help us evaluate this collection of practice tools, and we welcome suggestions for future versions.

1. **Which parts of the CRAST have you used?**

- ☐ CRAST Mini Screens (p1)
- ☐ AUDIT (p3)
- ☐ MST (p6)
- ☐ DAST (p7)
- ☐ PGSI (p9)
- ☐ 6-CIT (p11)
- ☐ PHQ-9 (p13)
- ☐ GAD-7 (p13)
- ☐ ACUK Workers Checklist (p15)
- ☐ Cranstoun Referral (p19)
- ☐ Blue Light Referral (p2)

2. **How have you used this tool?**

- ☐ In a practice situation with a person
- ☐ With a colleague in peer reflection
- ☐ By reflecting on how to use it in your practice

3. **Do you agree or disagree with these statements?**

	Disagree				*Agree*
The instructions were easy to follow	1	2	3	4	5
The tool was easy to use	1	2	3	4	5
The tool maintained focus on the topic	1	2	3	4	5
The tool aided communication	1	2	3	4	5
The tool opened up a wider conversation	1	2	3	4	5
The tool supported awareness raising	1	2	3	4	5
The tool helped in planning the next step	1	2	3	4	5

4. **Is there any part of the CRAST that you would change?**

5. **Is there anything you would add to the CRAST?**

6. **What other tools or resources would you like to see?**

Please return this form to nick1_shough@sandwell.gov.uk

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